

Exhibit A

SOCIAL SECURITY ADMINISTRATION				TOE 250				Form Approved OMB No. 0960-0014	
REQUEST TO BE SELECTED AS PAYEE	FOR SSA USE ONLY								FOR SSA USE ONLY
	Name or Ben. Sym.	Program	Date of Birth	Type	Gdn.	Cua.	Inst.	Nam.	
								DISTRICT OFFICE DESIGNATION:	
								STATE AND COUNTY CODE:	
PRINT IN INK: The name of the NUMBER HOLDER SOCIAL SECURITY NUMBER									
The name of the PERSON(S) for whom you are filing (the "claimant(s)") SOCIAL SECURITY NUMBER(S) (if different from above.)									
Answer item 1 ONLY if you are the claimant and want your benefits paid directly to you.									
1. I request that I be paid directly. CHECK HERE <input type="checkbox"/> and answer only items 3, 5, 6, and 8 before signing the form on page 4.									
I REQUEST THAT THE SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME, BLACK LUNG OR SPECIAL VETERANS BENEFITS FOR THE CLAIMANT(S) NAMED ABOVE BE PAID TO ME AS REPRESENTATIVE PAYEE.									
2. Explain why you think the claimant is not able to handle his/her own benefits. (In your answer, describe how he/she manages any money he/she receives now.) <input type="checkbox"/> Claimant is a minor child									
3. Explain why you would be the best representative payee. (Use Remarks if you need more space.)									
4. If you are appointed payee, how will you know about the claimant's needs? <input type="checkbox"/> Live with me or in the institution I represent. <input type="checkbox"/> Daily visits. <input type="checkbox"/> Visits at least once a week. <input type="checkbox"/> By other means. Explain:									
5. Does the claimant have a court-appointed legal guardian? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, enter the legal guardian's: NAME _____ ADDRESS _____ PHONE NUMBER _____ TITLE _____ DATE OF APPOINTMENT _____ Explain the circumstances of the appointment. (Use Remarks if you need more space.)									
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Exhibit A (continued)

6.	(a) Where does the claimant live? <input type="checkbox"/> Alone <input type="checkbox"/> In my home (Go to (b).) <input type="checkbox"/> With a relative (Go to (b).) <input type="checkbox"/> With someone else (Go to (b).) <input type="checkbox"/> In a board and care facility (Go to (b).)	<input type="checkbox"/> In a public institution (Go to (c).) <input type="checkbox"/> In a private institution (Go to (c).) <input type="checkbox"/> In a nursing home (Go to (c).) <input type="checkbox"/> In the institution I represent (Go to (c).)	
(b) Enter the names and relationships of any other people who live with the claimant.			
NAME		RELATIONSHIP	
(c) Enter the claimant's residence and mailing addresses (if different from yours). Residence: _____ Mailing: _____ Telephone Number: _____			
(d) Do you expect the claimant's living arrangements to change in the next year? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, explain what changes are expected and when they will occur. (Use Remarks if you need more space.)			
7.	If you are applying on behalf of minor child(ren) and you are not the parent, Does the child(ren) have a living natural or adoptive parent? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, enter: (a) Name of parent _____ (b) Address of parent _____ (c) Telephone number _____ (d) Does the parent show interest in the child? <input type="checkbox"/> YES <input type="checkbox"/> NO Please explain: _____		
8.	List the names and relationship of any (other) relatives or close friends who have provided support and/or show active interest with the claimant. Describe the type and amount of support and/or how interest is displayed.		
	NAME	ADDRESS/PHONE NO.	RELATIONSHIP
			DESCRIBE SUPPORT/INTEREST
9.	Check the block that describes your relationship to the claimant. (a) <input type="checkbox"/> Official of bank, agency or institution with responsibility for the person. Enter below which you represent: <input type="checkbox"/> Bank <input type="checkbox"/> Social Agency <input type="checkbox"/> Public Official <input type="checkbox"/> Institution: <input type="checkbox"/> Federal <input type="checkbox"/> State/Local <input type="checkbox"/> Private non-profit <input type="checkbox"/> Private proprietary institution. Is the institution licensed under State law? <input type="checkbox"/> YES <input type="checkbox"/> NO IF (a) ABOVE CHECKED, COMPLETE ONLY QUESTIONS 10 AND 11 AND SIGN THE FORM ON PAGE 4. (b) <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other Relative-Specify _____ <input type="checkbox"/> Legal Representative <input type="checkbox"/> Board and Care Home Operator <input type="checkbox"/> Other Individual-Specify _____ IF (b), (c), (d), or (e) ABOVE CHECKED, GO ON TO QUESTION 12		

Exhibit A (continued)

INFORMATION ABOUT INSTITUTIONS, AGENCIES AND BANKS APPLYING TO BE REPRESENTATIVE PAYEE	
10.	(a) Enter the name of the institution _____ (B) Enter the EIN of the institution _____
11.	Is the claimant indebted to your institution for past care and maintenance? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, give the amount of the debt, the date(s) the debt was incurred and a description of the debt.
INFORMATION ABOUT INDIVIDUALS APPLYING TO BE REPRESENTATIVE PAYEE	
12.	Enter: YOUR NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____ ANY OTHER NAMES YOU HAVE USED _____ OTHER SSN'S YOU HAVE USED _____
13.	How long have you known the claimant? _____
14.	Does the claimant owe you any money now or will he/she owe you money in the future? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, enter the amount he/she owes you, the date(s) the debt was/will be incurred and describe why the debt was/will be incurred.
15.	If the claimant lives with you, who takes care of the claimant when work or other activity take you away from home? What is his/her relationship to the claimant? _____
16.	(a) Main source of your income: <input type="checkbox"/> Employed (answer (b) below) <input type="checkbox"/> Self-employed (Type of Business _____) <input type="checkbox"/> Social Security or Black Lung benefits (Claim Number _____) <input type="checkbox"/> Pension (describe _____) <input type="checkbox"/> Supplemental Security Income payments (Claim Number _____) <input type="checkbox"/> AFDC (County & State _____) <input type="checkbox"/> Other Welfare (describe _____) <input type="checkbox"/> Other (describe _____) (b) Enter your employer's name and address: How long have you been employed by this employer? (If less than 1 year, enter name and address of previous employer in Remarks.)
17.	Have you ever been convicted of a felony? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES: What was the crime? _____ On what date were you convicted? _____ What was your sentence? _____ If imprisoned, when were you released? _____ If probation ordered, when did/will your probation end? _____

Exhibit A (continued)

18.	How long have you lived at your current address? (Give Date MM/YY) _____ (If less than 1 year, enter previous address in Remarks.)
REMARKS: (This space may be used for explaining any answers to the questions. If you need more space, attach a separate sheet.)	
PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE SIGNING THIS FORM	
<p>I understand that:</p> <ul style="list-style-type: none"> • I must use all payments made to me as the representative payee for the claimant's current needs or (if not currently needed) save them for his/her future needs. • I may be held personally liable for repayment if I misuse the payments or if I am at fault for any overpayment of benefits. <p>I agree to:</p> <ul style="list-style-type: none"> • Use the payments for the claimant's current needs and save any currently unneeded benefits for future use. • File an accounting report on how I used the payments when requested by the Social Security Administration. • Notify the Social Security Administration when the claimant dies, leaves my custody or otherwise changes his/her living arrangements or when I no longer have responsibility for his/her care and welfare. • Comply with the conditions for reporting certain events (listed on the attached sheet(s) which I will keep for my records) and for returning checks the claimant is not due. • File an annual report of earnings if required. • Notify the Social Security Administration as soon as I can no longer act as representative payee or the claimant no longer needs a payee. 	
<p>I know that anyone who makes or causes to be made a false statement or representation of material fact relating to a payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both.</p> <p>I affirm that all information I have given in this document is true.</p>	
SIGNATURE OF APPLICANT	
<p>Signature (first name, middle initial, last name) (Write in ink)</p> <p>Sign Here </p>	<p>Date (Month, day, year)</p> <p>Telephone number(s) at which you may be contacted during the day</p> <p>Area Code</p>
Print Your Name & Title (If a representative or employee of an institution/organization)	
Mailing Address (Number and Street, Apt. No., P.O. Box, or Rural Route)	
City and State	Zip Code Name of County
Residence Address (Number and Street, Apt. No., P.O. Box, or Rural Route)	
City and State	Zip Code Name of County
Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the applicant must sign below, giving their full addresses.	
1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State, and Zip Code)	Address (Number and Street, City, State, and Zip Code)
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Exhibit A (continued)

SOCIAL SECURITY

Information for Representative Payees Who Receive Social Security Benefits

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- the claimant **DIES** (Social Security entitlement ends the month before the month the claimant dies);
- the claimant **MARRIES**, if the claimant is entitled to child's, widow's, mother's fathers's, widower's or parent's benefits, or to wife's or husband's benefits as a divorced wife/husband, or to special age 72 payments;
- the claimant's marriage ends in **DIVORCE** or **ANNULMENT**, if the claimant is entitled to wife's, husband's or special age 72 payments;
- the claimant's **SCHOOL ATTENDANCE CHANGES** if the claimant is age 18 or over and entitled to child's benefits as a full time student;
- the claimant is entitled as a stepchild and the parents divorce (benefits terminate the month after the month the divorce becomes final);
- the claimant is under age 70 and **WORKS** for more than the annual limit (as determined each year) or for more than the allowable time (for work outside the United States);
- the claimant receives a **GOVERNMENT PENSION** or **ANNUITY** or the amount of the annuity changes, if the claimant is entitled to husband's, widower's, or divorced spouse's benefits;
- the claimant leaves your custody or care or otherwise **CHANGE ADDRESS**;
- the claimant **NO LONGER HAS A CHILD IN CARE**, if he/she is entitled to benefits because of caring for a child under age 16 or who is disabled;
- the claimant is confined to jail, prison, penal institution or correctional facility for **CONVICTION OF A CRIME**;
- the claimant is confined to a public institution by court order in connection **WITH A CRIME**.

IF THE CLAIMANT IS RECEIVING DISABILITY BENEFITS, YOU MUST ALSO REPORT IF:

- the claimant's **MEDICAL CONDITION IMPROVES**;
- the claimant **STARTS WORKING**;
- the claimant **applies for or receives WORKER'S COMPENSATION BENEFITS**, Black lung Benefits from the Department of Labor, or a public disability benefit;
- the claimant is **DISCHARGED FROM THE HOSPITAL** (if now hospitalized).

IF THE CLAIMANT IS RECEIVING SPECIAL AGE 72 PAYMENTS, YOU MUST ALSO REPORT IF:

- the claimant or spouse becomes **ELIGIBLE FOR PERIODIC GOVERNMENTAL PAYMENTS**, whether from the U.S. Federal government or from any State or local government;
- the claimant or spouse receives **SUPPLEMENTAL SECURITY INCOME** or **PUBLIC ASSISTANCE CASH BENEFITS**;
- the claimant or spouse **MOVES** outside the United States (the 50 States, the District of Columbia and the Northern Mariana Islands).

In addition to these events about the claimant, you must also notify us if:

- **YOU change your address**;
- **YOU are convicted of a felony**.

BENEFITS MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You should read the informational booklet we will send you to see how these events affect benefits. You may make your reports by telephone, mail or in person.

REMEMBER:

- payments must be used for the claimant's current needs or saved if not currently needed;
- you may be held liable for repayment of any payments not used for the claimant's needs or of any overpayment that occurred due to your fault;
- you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with a correct accounting;
- to tell us as soon as you know you will no longer be able to act as representative payee or the claimant no longer needs a payee.

Keep in mind that benefits may be deposited directly into an account set up for the claimant with you as payee. As soon as you set up such an account, contact us for more information about receiving the claimant's payments using direct deposit.

A REMINDER TO PAYEE APPLICANTS			
TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	BEFORE YOU RECEIVE A DECISION NOTICE	SSA OFFICE	DATE REQUEST RECEIVED
	AFTER YOU RECEIVE A DECISION NOTICE		

RECEIPT FOR YOUR REQUEST

Your request for Social Security benefits on behalf of the individual(s) named below has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect the benefits

payable, you—or someone for you—should report the change. The changes to be reported are listed on the reverse.

Always give us the claim number of the beneficiary when writing or telephoning about the claim.

If you have any questions about this application, we will be glad to help you.

BENEFICIARY	SOCIAL SECURITY CLAIM NUMBER

THE PRIVACY ACT

We are required by section 205(j) and 205(a) of the Social Security Act to ask you to give us the information on this form. This information is needed to determine if you are qualified to serve as representative payee. Although responses to these questions are voluntary, you will not be named representative payee unless you give us the answers to these questions.

Sometimes the law requires us to give out the facts on this form without your consent. We must release this information to another person or government agency if Federal law requires that we do so or to do the research and audits needed to administer or improve our representative payee program.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 10.5 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

Exhibit A (continued)

SUPPLEMENTAL SECURITY INCOME **Information for Representative Payees Who Receive SSI Benefits**

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- the claimant or any member of the claimant's household **DIES** (SSI eligibility ends with the month in which the claimant dies);
- the claimant's **HOUSEHOLD CHANGES** (someone moves in/out of the place where the claimant lives);
- the claimant **LEAVES THE U.S.** (the 50 states, the District of Columbia, and the Northern Mariana Islands) for 30 consecutive days or more;
- the claimant **MOVES** or otherwise changes the place where he/she actually lives;
- the claimant is **ADMITTED TO A HOSPITAL**, skilled nursing facility, nursing home, intermediate care facility, or other institution;
- the **INCOME** of the claimant or anyone in the claimant's household **CHANGES**;
- the **RESOURCES** of the claimant or anyone in the claimant's household **CHANGES**;
- the claimant or anyone in the claimant's household **MARRIES**;
- the marriage of the claimant or anyone in the claimant's household ends in **DIVORCE** or **ANNULMENT**;
- the claimant **SEPARATES** from his/her spouse;
- the claimant is confined to jail, prison, penal institution or correctional facility for **CONVICTION OF A CRIME**;
- the claimant is confined to a public institution by court order in connection **WITH A CRIME**.

IF THE CLAIMANT IS RECEIVING PAYMENTS DUE TO DISABILITY OR BLINDNESS, YOU MUST ALSO REPORT IF:

- the claimant's **MEDICAL CONDITION IMPROVES**;
- the claimant **GOES TO WORK**;
- the claimant's **VISION IMPROVES**, if the claimant is entitled due to blindness;

In addition to these events about the claimant, you must also notify us if:

- **YOU change your address**;
- **YOU are convicted of a felony**.

PAYMENT MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You should read the informational booklet we will send you to see how these events affect benefits. You may make your reports by telephone, mail or in person.

REMEMBER:

- payments must be used for the claimant's current needs or saved if not currently needed. (Savings are considered resources and may affect the claimant's eligibility to payment.);
- you may be held liable for repayment of any payments not used for the claimant's needs or of any overpayment that occurred due to your fault;
- you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with a correct accounting;
- to let us know as soon as you know you are unable to continue as representative payee or the claimant no longer needs a payee;
- you will be asked to help in periodically redetermining the claimant's continued eligibility or payment. You will need to keep evidence to help us with the redetermination (e.g., evidence of income and living arrangements).
- you may be required to obtain medical treatment for the claimant's disabling condition if he/she is eligible under the childhood disability provision.

Keep in mind that payments may be deposited directly into an account set up for the claimant with you as payee. As soon as you set up such an account, contact us for more information about receiving the claimant's payments using direct deposit.

A REMINDER TO PAYEE APPLICANTS			
TELEPHONE NUMBER(S) TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT	BEFORE YOU RECEIVE A DECISION NOTICE	SSA OFFICE	DATE REQUEST RECEIVED
	AFTER YOU RECEIVE A DECISION NOTICE		

RECEIPT FOR YOUR REQUEST

Your request for SSI payments on behalf of the individual(s) named below has been received and will be processed as quickly as possible.

You should hear from us within ____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect the benefits

payable, you—or someone for you—should report the change. The changes to be reported are listed on the reverse.

Always give us the claim number of the beneficiary when writing or telephoning about the claim.

If you have any questions about this application, we will be glad to help you.

BENEFICIARY	SOCIAL SECURITY CLAIM NUMBER

THE PRIVACY ACT

We are required by section 205(j) and 205(a) of the Social Security Act to ask you to give us the information on this form. This information is needed to determine if you are qualified to serve as representative payee. Although responses to these questions are voluntary, you will not be named representative payee unless you give us the answers to these questions.

Sometimes the law requires us to give out the facts on this form without your consent. We must release this information to another person or government agency if Federal law requires that we do so or to do the research and audits needed to administer or improve our representative payee program.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 10.5 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

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Exhibit A (continued)

BLACK LUNG BENEFITS
Information for Representative Payees Who Receive Black Lung Benefits

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- the claimant **DIES**;
- the claimant receives **STATE WORKER'S COMPENSATION** based on the miner's disability, or the amount of such compensation changes;
- the miner receives **UNEMPLOYMENT INSURANCE**;
- the claimant **IS WORKING** or **RETURNS TO WORK**;
- the claimant **MARRIES** or **REMARRIES**, if the claimant is entitled to child's, widow's, brother's or sister's benefits;
- the claimant begins to **RECEIVE SUPPORT PAYMENTS** from his/her spouse, if the claimant is entitled to brother's or sister's benefits;
- the claimant is **ADOPTED**, if the claimant is entitled to child's benefits;
- the claimant's **MEDICAL CONDITION IMPROVES**, if the claimant is entitled to disabled child's brother's or sister's benefits;
- the claimant is age 18 to 23 and **STOPS ATTENDING SCHOOL**, if the claimant is entitled to child's, sister's or brother's benefits.

In addition to these events about the claimant, you must also notify us if:

- **YOU change your address;**
- **YOU are convicted of a felony.**

BENEFITS MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You should read the informational booklet we will send you to see how these events affect benefits. You may make your reports by telephone, mail or in person.

REMEMBER:

- payments must be used for the claimant's current needs or saved if not currently needed;
- you may be held liable for repayment of any payments not used for the claimant's needs or of any overpayment that occurred due to your fault;
- you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with a correct accounting;
- to let us know as soon as you know you are unable to continue as representative payee or the claimant no longer needs a payee.

Keep in mind that benefits may be deposited directly into an account set up for the claimant with you as payee. As soon as you set up such an account, contact us for more information about receiving the claimant's payments using direct deposit.

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Exhibit A (continued)

SPECIAL BENEFITS FOR WORLD WAR II VETERANS
Information for Representative Payees Who Receive Special Benefits for WW II Veterans

YOU MUST NOTIFY THE SOCIAL SECURITY ADMINISTRATION PROMPTLY IF ANY OF THE FOLLOWING EVENTS OCCUR AND PROMPTLY RETURN ANY PAYMENT TO WHICH THE CLAIMANT IS NOT ENTITLED:

- the claimant DIES (special veterans entitlement ends the month after the claimant dies);
- the claimant returns to the United States for a calendar month or longer;
- the claimant moves or changes the place where he/she actually lives;
- the claimant receives a pension, annuity or other recurring payment (includes workers' compensation, veterans benefits or disability benefits), or the amount of the annuity changes;
- the claimant is or has been deported or removed from U.S.;
- the claimant left a jurisdiction within the U.S. to avoid prosecution or custody or confinement after conviction for a crime that is a felony, or in New Jersey, a high misdemeanor;
- the claimant is in violation of a condition of probation or parole.

In addition to these events about the claimant, you must also notify us if:

- YOU change your address;
- YOU are convicted of a felony.

BENEFITS MAY STOP IF ANY OF THE ABOVE EVENTS OCCUR. You can make your reports by telephone, mail or in person. You can contact any U.S. Embassy, Consulate, Veterans Affairs Regional Office in the Philippines or any U.S. Social Security Office.

REMEMBER:

- payments must be used for the claimant's current needs or saved if not currently needed;
- you may be held liable for repayment of any payments not used for the claimant's needs or of any overpayment that occurred due to your fault;
- you must account for benefits when so asked by the Social Security Administration. You will keep records of how benefits were spent so you can provide us with a correct accounting;
- to let us know as soon as you know you are unable to continue as representative payee or the claimant no longer needs a payee.

Exhibit A (continued)

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	AFTER YOU RECEIVE A DECISION NOTICE		

RECEIPT FOR YOUR REQUEST

Your request for Special Benefits for WW II Veterans on behalf of the individual(s) named below has been received and will be processed as quickly as possible.

You should hear from us within _____ days after you have given us all the information we requested. Some claims may take longer if additional information is needed.

In the meantime, if you change your address, or if there is some other change that may affect the benefits

payable, you—or someone for you—should report the change. The changes to be reported are listed on the reverse.

Always give us the claim number of the beneficiary when writing or telephoning about the claim.

If you have any questions about this application, we will be glad to help you.

BENEFICIARY	SOCIAL SECURITY CLAIM NUMBER

THE PRIVACY ACT

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Sometimes the law requires us to give out the facts on this form without your consent. We must release this information to another person or government agency if Federal law requires that we do so or to do the research and audits needed to administer or improve our representative payee program.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

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